TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Orthopedic Hospital

Respondent Name
Liberty Mutual Insurance Co

MFDR Tracking Number
M4-17-0029-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
September 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should have been paid in accordance with 28 T.A.C. § 134.403, which states, "(1) [t]he sum of the Medicare facility specific reimbursement amount and any applicable outlier amount shall be multiplied by (A) 200 percent…" This is the formula to be used absent certain circumstances that do not apply to the present case. Using this formula, the hospital would have been entitled to $18,183.98 in reimbursement."

Amount in Dispute: $7,462.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT codes were paid at 200% CMS rate per TX Fee Schedule except CPT 25270 x2, CPT 25260 and 64708 were denied X263 (The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure) as correct coding is not allowed. Services billed without CPT or HCPCS codes denied X936 (CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE). HCPCS J codes and laboratory charges are packaged items per OPPS; denied U634 (Procedure code not separately payable under Medicare and or Fee Schedule guidelines)."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2016 February 5, 2016	Outpatient hospital services	$7,462.59	$2,340.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X936 - CPT or HCPC is required to determine if services are payable
   - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
   - X263 – The code billed does not meet the level/description of the procedure performed/documented
   - MTPR – Outpatient significant procedures subject to multiple procedure reduction of 50 percent
   - MOPS – Services reduced to the outpatient perspective payment system
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration
   - X133 – This charge was not reflected in the report as one of the procedure or services performed
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Was the carriers' denial supported?
2. What is the applicable rule that pertains to reimbursement?
3. How is the maximum allowable reimbursement calculated?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is related to services provided in an outpatient hospital setting.

   Review of the submitted medical claim finds that eight procedures were submitted:

   - 25270 x 2
   - 25280 x3
   - 25260
   - 64782
   - 64708

   The respondents states, "CPT codes were paid at 200% CMS rate per TX Fee Schedule except CPT 25270 x 2, CPT 25260 and CPT 64708 were denied, 263 – "The code billed does not meet the level/description of the procedure performed/documented."

   The definition of the denied codes is:

   - 25270– "Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle
   - 25260– "Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
   - 64708– "Neuroplasty, major peripheral nerve, arm or leg, open; other than specified

   Page 2 of the "Operative Report" identified the following:

   - Tenotomy at the muscultendinous junction of the brachioradialis was performed
   - …a release of the pronator teres was performed with the Bovie cautery
   - …the wrist underwent a musculotendinous tenotomy of the extensor carpi radialis longus

- …a fractional lengthening of the extensor carpi radialis brevis with repair of Ethibod suture
- ...a neurectomy was performed with sharp dissection and Bovie cautery
- Flexor pollicis longus fractional lengthening at the muscle tendon junction was performed
- Pronator quadratus was released
- The sublimis and the profundus muscle groups index, middle, ring, and little finger underwent a fractional lengthening and brought the wrist and fingers into a more functional position.

Review of the report finds one claim line for code 25270 (Repair of tendon or muscle, extensor) is supported by (extensor carpi radialis brevis with repair of Ethibod suture). Therefore, one unit is recommended for payment.

The carriers' denial of one unit for code 25270, code 25260, and 64708 is supported. No additional payment is recommended.

The reimbursement for the allowed services is calculated below.

2. The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

   The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used in the calculation of the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
   - **Multiple procedure discounts -** Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time;

3. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The services in dispute are calculated as follows:

Procedure Code	APC	Status Indicator	Does 50% reduction apply	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9615	40% non-labor related	Payment	Maximum allowable reimbursement
25270	5122	T	No	$2,395.59	$2,395.59 x 60% = $1,437.35	0.9615 x $1,437.37 = 1,382.01	$2,395.59 x 40% = $958.24	$1,382.01 + $958.24 = $2,340.25	$2,340.25 x 200% = $4,680.50
25280	5122	T	Yes	$2,395.59 x 50% = $1,197.80	$1,197.80 x 60% = $718.68	$718.68 x 0.9615 = $691.01	$1,197.80 x 40% = $479.12	$691.01 + $479.12 = $1,170.13	$1,170.13 x 200% = $2,340.26
25280	5122	T	Yes	$1,197.80 x 50% =	$1,197.80 x 60% = $718.68	$718.68 x 0.9615 = $691.01	$1,197.80 x 40% = $479.12	$691.01 + $479.12 = $1,170.13	$1,170.13 x 200% = $2,340.26
25280	5122	T	Yes	$1,197.80 x 50% =	$1,197.80 x 60% = $718.68	$718.68 x 0.9615 = $691.01	$1,197.80 x 40% = $479.12	$691.01 + $479.12 = $1,170.13	$1,170.13 x 200% = $2,340.26
64782	5431	T	Yes	$1,392.56 x 50% = $696.28	$696.28 x 60% = $417.77	$417.77 x 0.9615 = $401.69	$696.28 x 40% = $278.51	$401.69 + $278.51 = $680.20	$680.20 x 200% = $1,360.40
								Total	$13,061.68

The remaining services are classified as follows:

- Procedure code J1170 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2704 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048, date of service January 7, 2016, has status indicator Q4. Status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3."
- Procedure code 25270 was denied. Review of the submitted evidence finds the carriers' denial is supported. No additional payment is recommended.
- Procedure code 25260 was denied. Review of the submitted evidence finds the carriers' denial is supported. No additional payment is recommended.

- Procedure code 64708 was denied. Review of the submitted evidence finds the carriers' denial is supported. No additional payment is recommended.
- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.

4. The total allowable reimbursement for the services in dispute is $13,061.68. This amount less the amount previously paid by the insurance carrier of $10,721.36 leaves an amount due to the requestor of $2,340.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,340.32.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,340.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 7, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.